DHMH Million Hearts Initiatives

Million Hearts Symposium
February 10, 2015

Maryland Department of Health and Mental Hygiene
Prevention and Health Promotion Administration
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MARYLAND
DEPARTMENT OF HEALTH & MENTAL HYGIENE

MISSION AND VISION

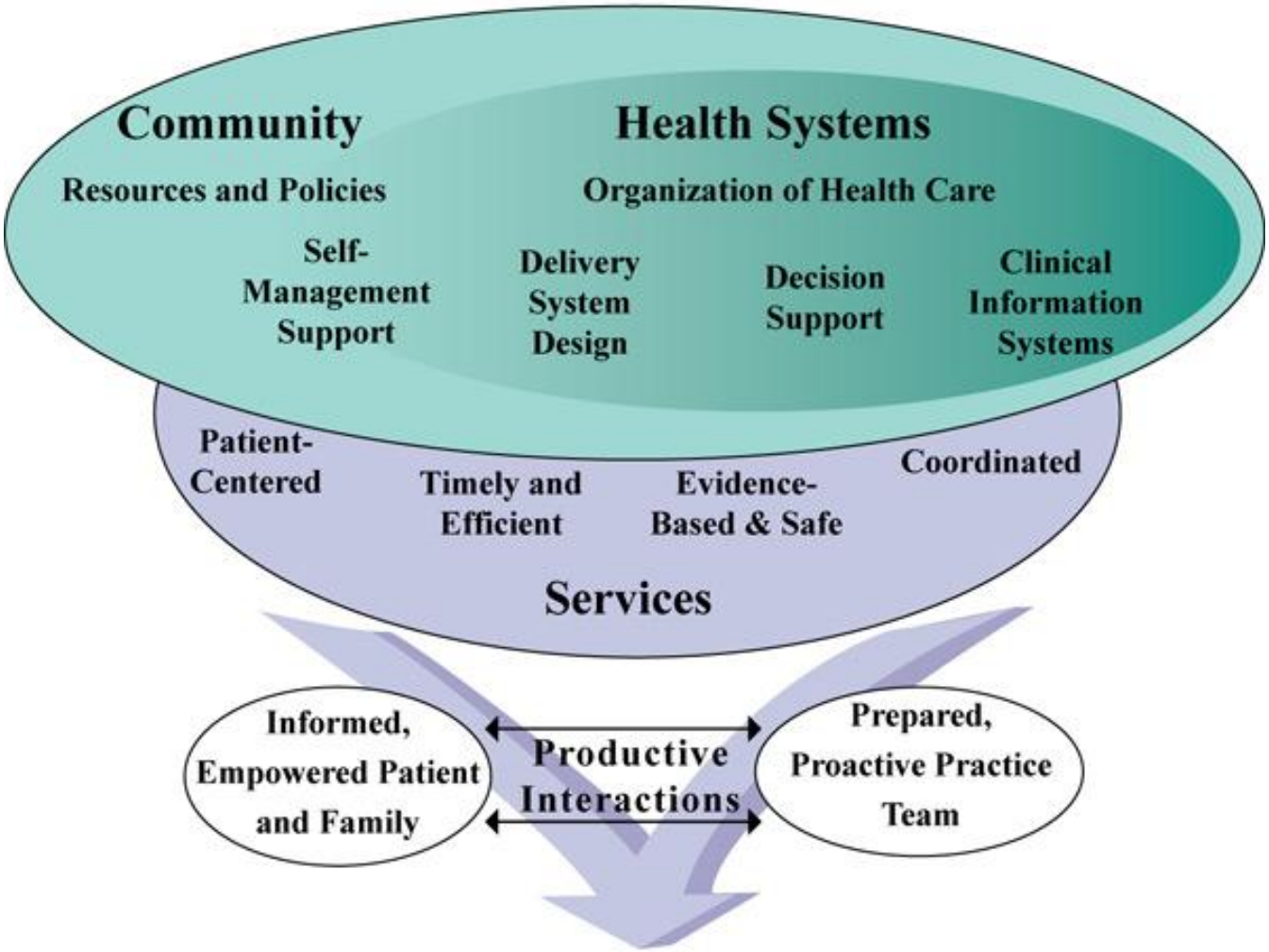
MISSION

- The mission of the Prevention and Health Promotion Administration is to protect, promote and improve the health and well-being of all Marylanders and their families through provision of public health leadership and through community-based public health efforts in partnership with local health departments, providers, community based organizations, and public and private sector agencies, giving special attention to at-risk and vulnerable populations.

VISION

- The Prevention and Health Promotion Administration envisions a future in which all Marylanders and their families enjoy optimal health and well-being.

The Care Model



Improved Outcomes

Developed by The MaColl Institute

DHMH Role In Accelerating Improvement

- Symposiums that identify priorities and highlight opportunities in improving systems, policy, and environment to prevent and control chronic diseases
- Engage payers to align financial incentives
- Provide funding and resources to support and align Maryland Million Hearts efforts statewide
- Strengthen *Learning Collaboratives* for continuous improvement
- Disseminate success stories to regional and national stakeholders

Leveraging Chronic Disease Grants

- Community Transformation Grant (CTG)
- Preventive Health and Health Services (PHHS) Block Grant
- State Public health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health (1305)
- State and Local Public Health Action to Prevent Obesity, Diabetes and Heart Disease (1422)
- ASTHO Million Hearts

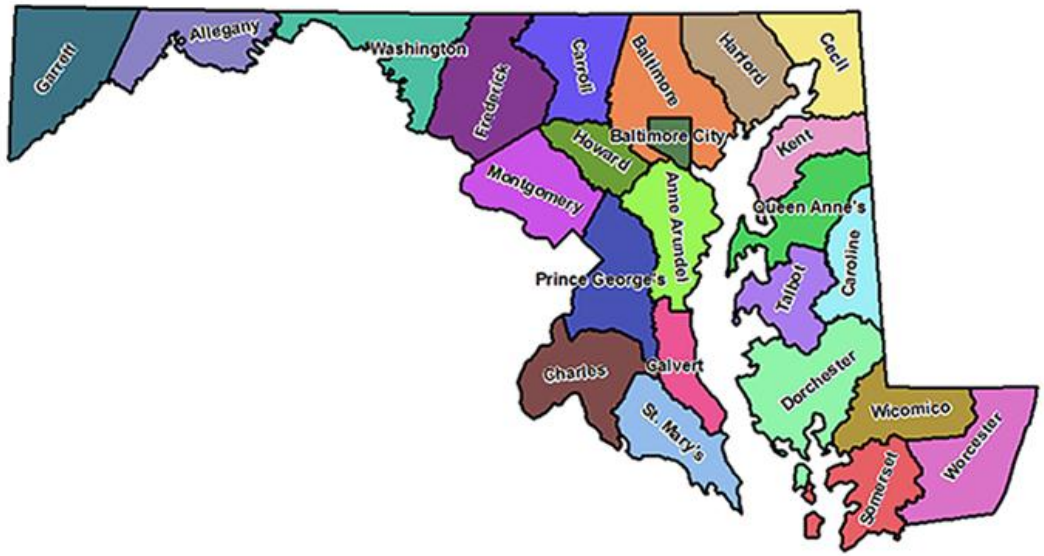
Maryland Tools and Resources

Maryland Million Hearts Implementation Guide

- Provides strategies, potential partners, metrics, and guidance documents for 5 core components:
  - Local Public Health Action
  - Public Health and Health Care Integration
  - Expanding use of Health Information Technology
  - Worksite Wellness
  - Promoting Team-Based Care

Local Public Health Action

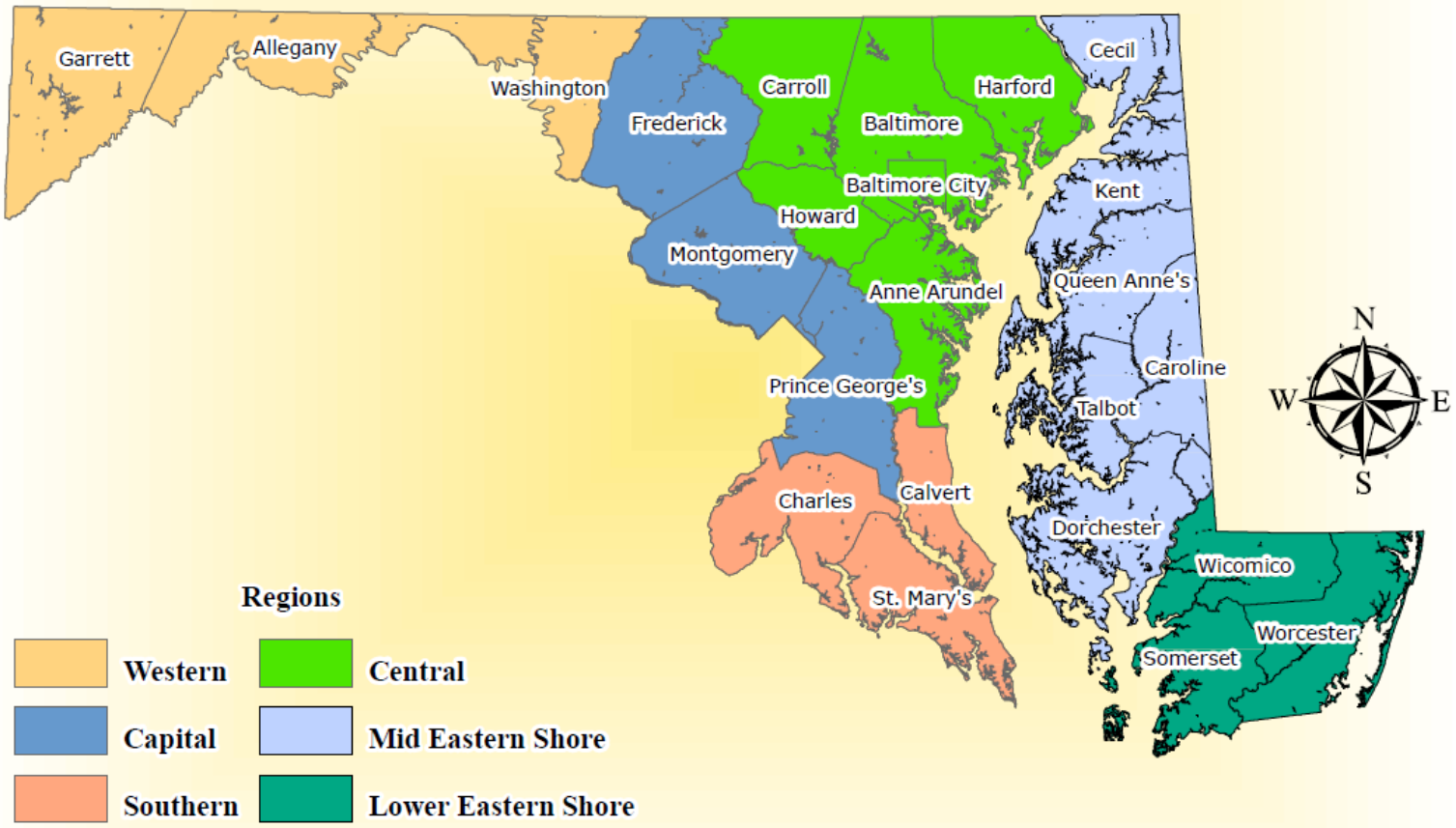
- Representatives from:
  - LHDs
  - Hospitals
  - Business
  - Education
  - Human Services
  - Mental Health
  - Housing
  - Land Use/Planning
  - Faith Based
  - FQHC
  - Private Practice
  - LHD
  - Local Health Improvement Coalitions



Environmental Solutions

- MSDE Early child care
- H2E
- Environmental Food Scan
- Maryland Rural Health
- Healthy Corner Stores
- School Health Council

Healthiest Maryland Business Regions



Created by Center for Chronic Disease Prevention and Control
Prevention and Health Promotion Administration, Maryland Department of Health and Mental Hygiene.

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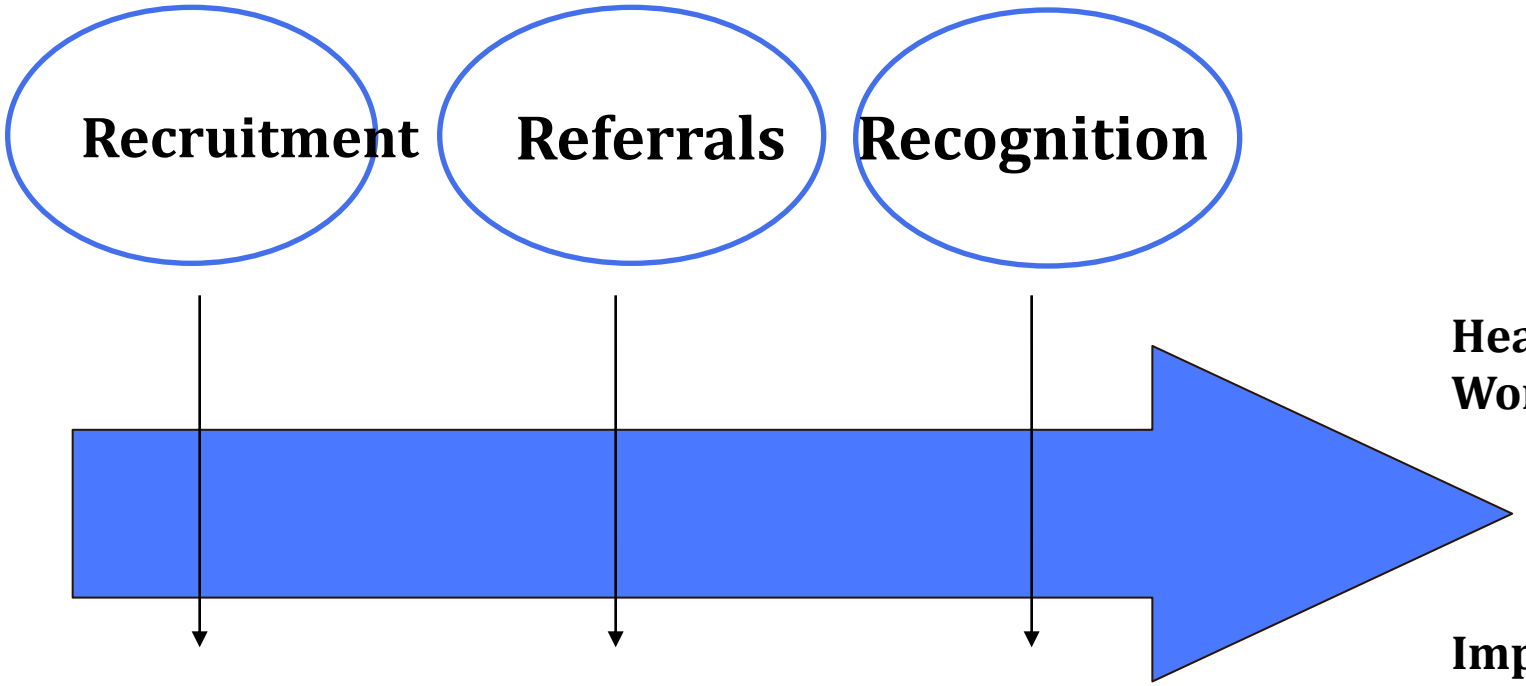
Healthiest Maryland Businesses



Increased awareness of current wellness policies and opportunities for improvement

Providing resources and support to businesses- targeting sectors experiencing health disparities

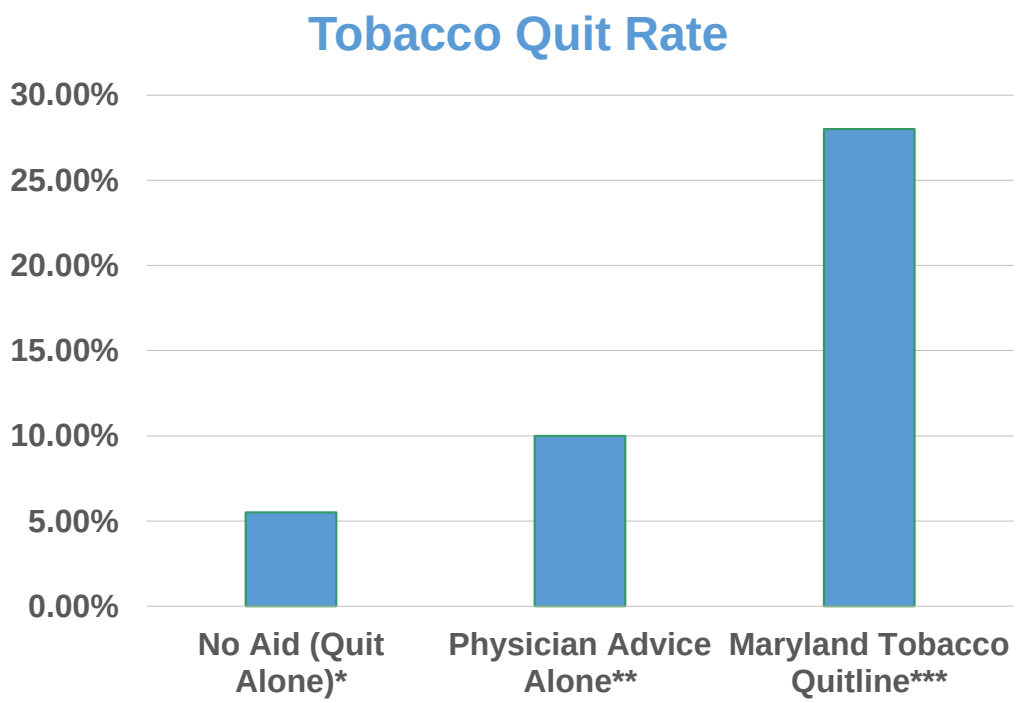
Honoring participating healthy businesses statewide

Maryland Tobacco Quitline

- Free & confidential, evidence-based counseling available 24/7 to assist Marylanders ages 13 years and older in quitting any tobacco use
  - Phone Counseling
  - Text Support
  - Web Support
- Available in English, Spanish, and 200 other languages via translation
- Free 4 week NRT supply available
- Fax to Assist : **www.smokingstopshere.com**
- Ask, Advise, and Refer: **www.helppatientsquitmd.org**

Quitline Outcomes

- 96% of participants **would recommend** the program.
- Participants who used **patches, gum, or medication** were much more satisfied with the program than those who didn't use these.
- 3 out of every 4 callers smoked less cigarettes at the end of the program than when they enrolled – **the program works**!



Systems Solutions

- MACHC: FQHC automatic aggregation of data across multiple EHRs
- Enhance sustainability and improved QI processes
- Partnering with the Primary Care Association to:
  - Develop data warehouse for FQHC data standardization
  - Provide QI coaching to FQHC on proper HTN measurement to improve data quality and care delivery
  - QI Council represented by FQHCs

Systems Solutions

Maryland Learning Collaborative (MLC)

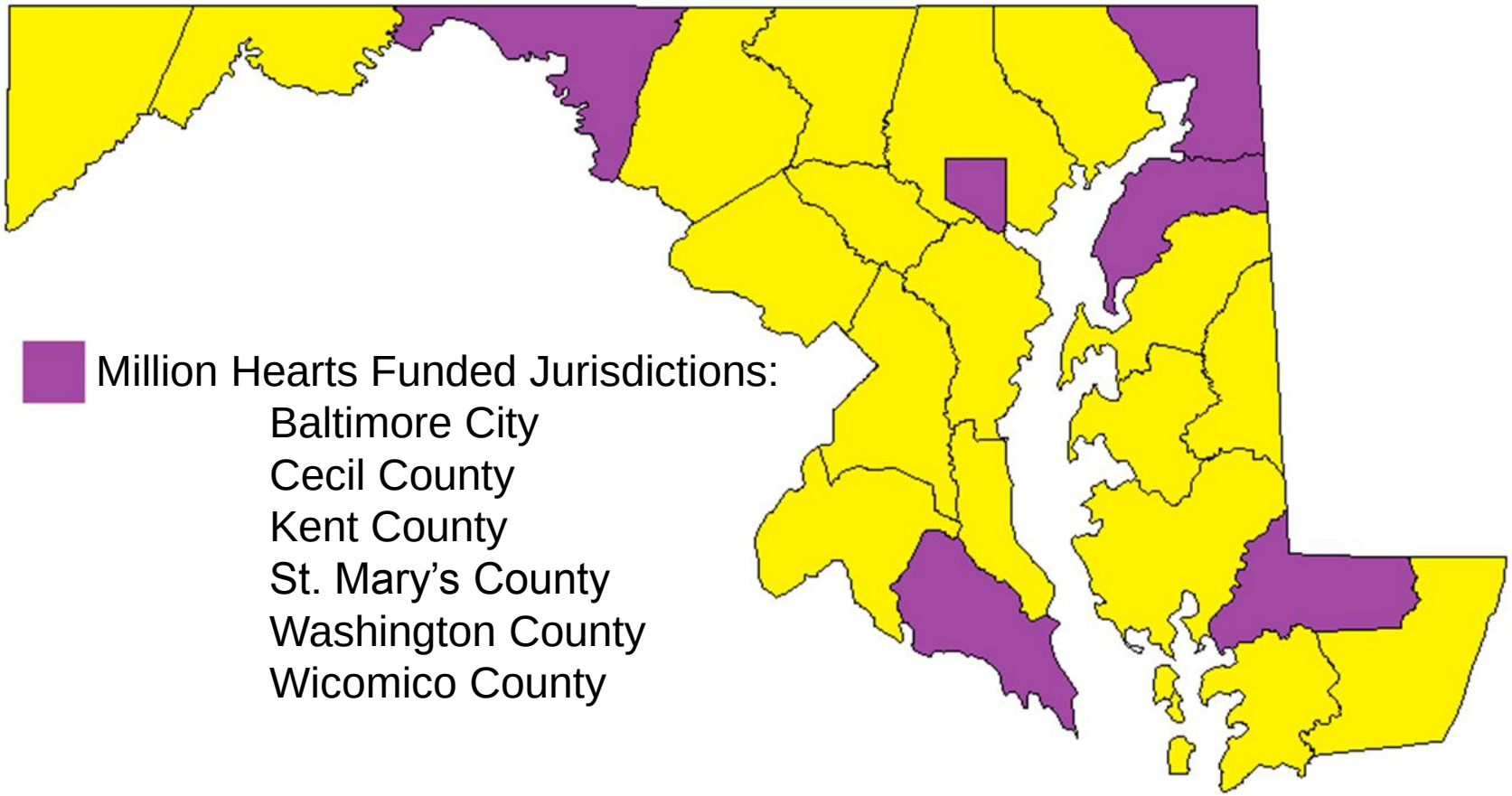
- 52 community PCMH practices and FQHC
  - 17 practices currently involved
- Developed protocols to better screen, diagnose, and manage hypertension
  - Proper blood pressure measurement training
  - Reviewed patient records and compiled case studies
  - Developed process to re-engage patients
  - Evaluated protocols for HTN evaluation and management

Community Solutions

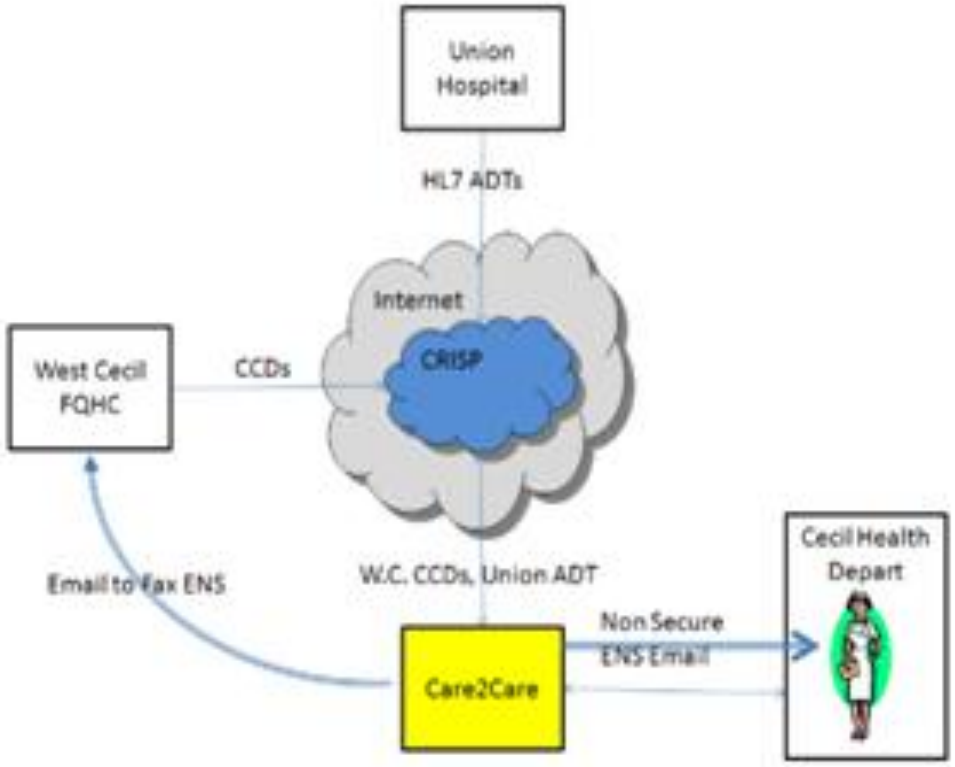
Faith Based Initiatives

- Washington County Parish Nurse Program
  - Promoting self monitoring of blood pressure and lifestyle change
  - Significant improvement in blood pressure
- Church/Community Health Awareness and Monitoring Program (CHAMP): Freedom Walk Project Taking Action Intervention
  - Promoting physical activity through faith based walking clubs
  - Significant improvements in blood pressure

Provider to Community Linkages



Community Clinical Data Sharing



- Bidirectional data sharing

Community-Based Screenings and Referrals

- HTN screenings provided through local community events, health fairs, grocery stores, libraries, workplaces, faith-based settings, and other community venues.
  - 130 community HTN screening and education events were held by the 4 LHDs
  - 3,820 individuals were screened
  - 1,371 referrals were made to community programs
  - 1,236 referrals were made to health care providers

Medical Home Extenders

- Sinai Hospital program to improve high-risk patients' health status, and reduce unnecessary emergency and inpatient admissions
- Brings additional resources to the Park Heights Neighborhood in Baltimore City
  - Community-focused nurses
  - Social workers
  - Community Health Workers
  - Hospitalist Physicians
  - FQHC

Collaboration with Medicaid

- Chronic disease management programs for Maryland Medicaid population led by the State's managed care organizations
  - Value Based Purchasing Program
- Reimbursement for individual tobacco cessation counseling services with no age limit
  - Primary care physicians, nurse practitioners, and nurse midwives

Value Based Insurance Design (VBID)

- VBID aims to align patients' out-of-pocket costs, such as copayments and deductibles, with the value of health services
  - Incentivize prevention
  - Disincentives unhealthy behavior
- Value Based Purchasing
- Task Force created as part of the Maryland Health Benefit Exchange Act of 2012
  - Develop policy options and clinical areas and services for VBID
  - Disseminate outcomes to inform value discussions

Collaboration with Medicaid

CONTROLLING HIGH BLOOD PRESSURE					
	COMMERCIAL		MEDICAID	MEDICARE	
YEAR	HMO	PPO	HMO	HMO	PPO
2012	63.0	57.4	56.3	63.6	58.6
2011	65.4	58.4	56.8	64.0	60.6
2010	63.4	56.7	55.6	61.9	55.7
2009	64.1	48.3	55.3	59.8	54.8
2008	63.4	–	55.8	58.5	–
2007	62.2	–	53.5	57.6	–
2006	59.7	48.9	53.1	56.8	51.2
2005	68.8	60.9	61.5	66.4	60.6
2004	66.8	–	61.4	64.6	–
2003	62.2	–	58.6	61.4	–
2002	58.4	–	52.3	56.9	–
2001	55.4	–	53.0	53.6	–
2000	51.5	–	–	–	–
1999	39.0	–	–	–	–

HEDIS Measure Definition

The percentage of adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.

RFP for MCOs

Targeted enhanced care management resources to address NQF 0018

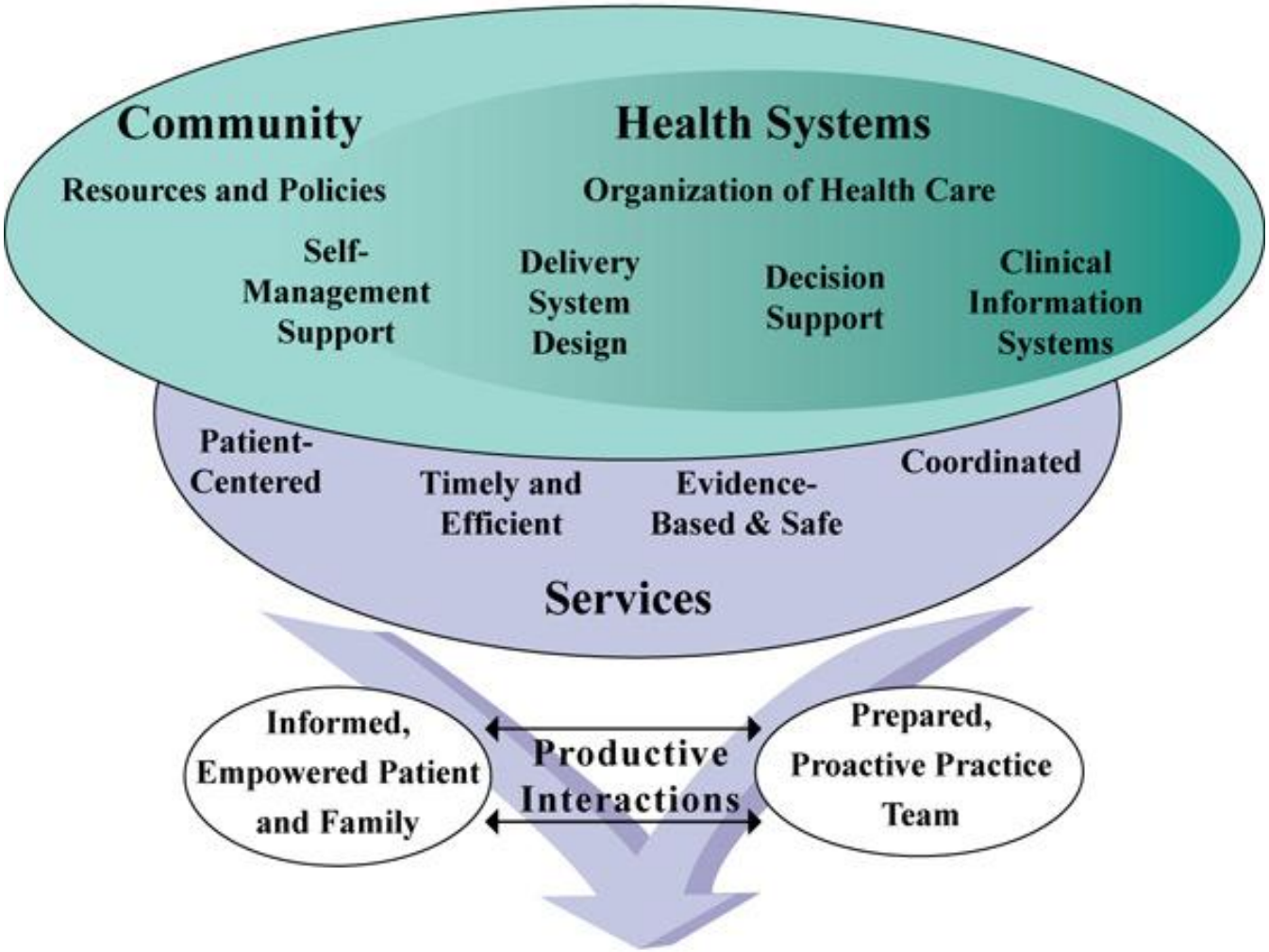
Diabetes Prevention Program (DPP)

- Smoking, Hypertension, High Cholesterol, and Diabetes are the major modifiable risk factors for cardiovascular disease
  - Physical activity, diet, and obesity mostly contribute to CVD risk by modifying the effects of the above risk factors
- Weight loss of 5% to 7% reduced the risk of developing type 2 diabetes by 58% in people with **prediabetes**
- Prediabetes (A1c 5.7 to 6.4%) is the critical time to intervene along disease spectrum!
- 19 CDC-recognized DPPs in Maryland
  - https://nccd.cdc.gov/DDT_DPRP/Registry.aspx

Diabetes Self Management Education (DSME)

- DSME addresses:
  - Healthy Eating
  - Being Active
  - Monitoring/Taking Medication
  - Problem Solving
  - Healthy Coping
  - Reducing Risks
- DSME has potential benefits on cardiovascular risk factors
- Covered by Medicare(if given in group setting by ADA, AADE certified program, referred by certified provider)
- DSME programs in Maryland
  - 39 ADA accredited diabetes education programs
  - 14 AADE accredited diabetes education programs
  - 45 Chronic Disease Self-Management Program workshops in 7 counties
  - 24 Diabetes Self-Management Program workshops in 8 counties

The Care Model



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